FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021568

Facility Name: The Elms

Address: 1212 Madelyn Avenue (Number) Macomb, IL (City) 61455 (Zip Code)

County: McDonough

Telephone Number: (309) 837-5482 **Fax #** (309) 833-1054

IDPA ID Number: 37-6001537001

Date of Initial License for Current Owners: 10/11/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles Kneedy **Telephone Number:** (309) 837-5482

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/00 to 11/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Charles Kneedy
(Title) Administrator

Paid Preparer
(Signed) See Attached Accountant's Report (Date)
(Print Name and Title) Clifton Gunderson LLP
(Firm Name & Address) 301 S.W. Adams, Suite 900, P.O. Box 1835 Peoria, IL 61656-1835
(Telephone) (309) 671-4500 Fax # (309) 671-4508

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 98

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		578		578	8
9	SNF/PED					9
10	ICF	22,060	11,385		33,445	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,060	11,963		34,023	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.12%

D. How many bed-hold days during this year were paid by Public Aid?
261 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/11/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: N/A Fiscal Year: 11/30/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	265,487	19,249	6,771	291,507		291,507	(218)	291,289			1
2	Food Purchase		156,700		156,700		156,700	(2,830)	153,870			2
3	Housekeeping	141,658	21,056	1,641	164,355		164,355		164,355			3
4	Laundry	62,005	62,875		124,880		124,880		124,880			4
5	Heat and Other Utilities			89,542	89,542		89,542		89,542			5
6	Maintenance	82,133	25,771	13,507	121,411		121,411	11,920	133,331			6
7	Other (specify):* Waste Removal			8,064	8,064		8,064		8,064			7
8	**TOTAL General Services**	551,283	285,651	119,525	956,459		956,459	8,872	965,331			8
	B. Health Care and Programs											
9	Medical Director			360	360		360		360			9
10	Nursing and Medical Records	1,549,946	107,458	6,080	1,663,484		1,663,484	(38,718)	1,624,766			10
10a	Therapy	94,401		9,306	103,707		103,707		103,707			10a
11	Activities	90,186	468	5,430	96,084		96,084	(59)	96,025			11
12	Social Services	57,310		1,582	58,892		58,892		58,892			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,791,843	107,926	22,758	1,922,527		1,922,527	(38,777)	1,883,750			16
	C. General Administration											
17	Administrative	66,901			66,901		66,901		66,901			17
18	Directors Fees											18
19	Professional Services			12,514	12,514		12,514		12,514			19
20	Dues, Fees, Subscriptions & Promotions			16,053	16,053		16,053	(2,991)	13,062			20
21	Clerical & General Office Expenses	109,445	10,206	39,526	159,177		159,177	(22,585)	136,592			21
22	Employee Benefits & Payroll Taxes			409,070	409,070		409,070	361,970	771,040			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,615	3,615		3,615		3,615			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							25,642	25,642			26
27	Other (specify):*											27
28	**TOTAL General Administration**	176,346	10,206	480,778	667,330		667,330	362,036	1,029,366			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,519,472	403,783	623,061	3,546,316		3,546,316	332,131	3,878,447			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Elms #0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			146,346	146,346		146,346		146,346			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							100,000	100,000			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Loss on Disposal			1,216	1,216		1,216		1,216			36
37	TOTAL Ownership			147,562	147,562		147,562	100,000	247,562			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,675	53,675		53,675		53,675			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			53,675	53,675		53,675		53,675			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,519,472	403,783	824,298	3,747,553		3,747,553	432,131	4,179,684			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,830)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,828)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(17,095)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(175)	20		17
18	Fines and Penalties				18
19	Entertainment	(3,292)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,816)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(56,922)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (87,958)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	520,089	6,22,26,32	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 520,089		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 432,131		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

The Elms

ID# 0021568

Report Period Beginning: 12/1/00

Ending: 11/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Food Service Reimbursement	$ (218)	1	1
2	Pop and Vending	(16,830)	21	2
3	Nursing Reimbursement	(38,718)	10	3
4	Clerical and General Office	(927)	21	4
5	Employee Benefit Reimbursement	(170)	22	5
6	Activity Reimbursement	(59)	11	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(56,922)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(218)	0	0	0	0	0	0	0	0	0	0	(218)	1
2	Food Purchase	(2,830)	0	0	0	0	0	0	0	0	0	0	(2,830)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	11,920	0	0	0	0	0	0	0	0	0	11,920	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,048)	11,920	0	0	0	0	0	0	0	0	0	8,872	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(38,718)	0	0	0	0	0	0	0	0	0	0	(38,718)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(59)	0	0	0	0	0	0	0	0	0	0	(59)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(38,777)	0	0	0	0	0	0	0	0	0	0	(38,777)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,991)	0	0	0	0	0	0	0	0	0	0	(2,991)	20
21	Clerical & General Office Expenses	(22,585)	0	0	0	0	0	0	0	0	0	0	(22,585)	21
22	Employee Benefits & Payroll Taxes	(3,462)	365,432	0	0	0	0	0	0	0	0	0	361,970	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	25,642	0	0	0	0	0	0	0	0	0	25,642	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(29,038)	391,074	0	0	0	0	0	0	0	0	0	362,036	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(70,863)	402,994	0	0	0	0	0	0	0	0	0	332,131	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Elms **#** 0021568 **Report Period Beginning:** 12/1/00 **Ending:** 11/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,095)	17,095	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	100,000	0	0	0	0	0	0	0	0	0	100,000	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(17,095)	117,095	0	0	0	0	0	0	0	0	0	100,000	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(87,958)	520,089	0	0	0	0	0	0	0	0	0	432,131	45

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				McDonough County	Macomb, IL	Local Gov't Unit
				Macomb Public Bldg.		
				Commision	Macomb, IL	Local Gov't Unit

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance	$	Macomb Public Building Commision	N/A	$ 11,920	$ 11,920	1
2	V		Employer's Share of IMRF and						2
3	V	22	FICA		McDonough County	N/A	305,855	305,855	3
4	V	22	Worker's Compensation Insurance		McDonough County	N/A	59,577	59,577	4
5	V	26	Property and Liability Insurance		McDonough County	N/A	25,642	25,642	5
6	V	32	Interest		Macomb Public Building Commision	N/A	16,509	16,509	6
7	V	32	Interest-Amortization of Bond Costs		Macomb Public Building Commision	N/A	586	586	7
8	V	34	Rent-Facility and Grounds		McDonough County	N/A	100,000	100,000	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 520,089	$ * 520,089	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Not Applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Macomb Public Building	X		Expansion of Facility		12/1/93	$ 450,000	$ 294,432	2/1/09	.0400 to	$ 16,509	1
2	Commision Bonds									0.0575		2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 450,000	$ 294,432			$ 16,509	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 450,000	$ 294,432			$ 16,509	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Elms COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0021568

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,100 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility Site (acres)	7	1975	$ 49,000	1
2					2
3	TOTALS	7		$ 49,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1977	1976	$ 1,995,722	$ 39,914	50	$ 39,914	$	$ 964,599	4
5	Building		1978	1978	30,054	601	50	601		14,426	5
6	Building		1980	1980	186,829	3,737	50	3,737		79,063	6
7	Building		1981	1981	32,336	647	50	647		13,528	7
8	Storm Sewers		1977	1977	77,642	2,588	30	2,588		62,631	8
	Improvement Type**										
9	Storage Building E			1978	15,445		20			15,445	9
10	Road & Parking Lot E			1978	27,033	1,081	25	1,081		25,408	10
11	Rock for Driveway E			1979	2,381		10			2,381	11
12	Doors/Storage Building E			1980	320		10			320	12
13	Furnace/Storage Building E			1980	652		15			652	13
14	Bathroom Heaters			1981	4,342		10			4,342	14
15	Annunciator Panel			1981	1,867		10			1,867	15
16	Fire Sprinklers			1981	1,455	58	25	58		1,220	16
17	Energy Management System			1982	18,400	920	20	920		17,787	17
18	Tile			1982	2,956		10			2,956	18
19	Dietary Remodeling			1982	26,152	872	30	872		15,692	19
20	Lighting Fixtures			1982	303		10			303	20
21	Dietary Remodeling			1983	270,793	9,026	30	9,026		162,475	21
22	Windbreak			1983	950	32	30	32		571	22
23	Tile			1983	1,356		10			1,356	23
24	Tile			1983	736		10			736	24
25	Parking Lot Lights			1983	5,100	255	20	255		4,590	25
26	Road E			1983	24,963	998	25	998		18,971	26
27	Air Handling Unit			1985	6,100	305	20	305		5,083	27
28	Exhaust Fan			1985	2,473		10			2,473	28
29	Transformer			1985	1,675		10			1,675	29
30	Ceiling Tiles			1986	457		10			457	30
31	Compressor			1986	1,391	93	15	93		1,385	31
32	Generator			1987	1,557	78	20	78		1,111	32
33	Ceiling Tiles			1987	1,540		10			1,540	33
34	Exchange System			1988	7,622	381	20	381		5,048	34
35	Driveway Paving			1988	12,172	609	15	609		8,068	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Storm Sewer	1978	$ 5,078	$		$	$	$	37
38	Landscape	1977	24,326						38
39	Landscape	1978	15,382						39
40	Landscape	1980	500						40
41	Landscape	1981	19,864						41
42	Asphalt Parking Lot	1988	33,039						42
43	Holby Tempering Valves	1989	2,530						43
44	Energy Management System	1989	16,500						44
45	Control Panel	1989	3,400						45
46	Driveway Improvements	1989	1,152						46
47	Ceiling Fans (4)	1990	3,600						47
48	Nurses Station	1990	4,659						48
49	Energy Management System	1990	16,363						49
50	Paint/Wall Covering/Bath	1991	7,387						50
51	Wall Covering N & S Corridor	1991	9,407						51
52	Painting/Labor	1991	2,600						52
53	Drywall/ N & S Corridor	1991	10,800						53
54	Tempered Glass	1991	4,787						54
55	Additional Wall Covering N & S Corridor	1991	7,018						55
56	Roof Repair	1991	43,249						56
57	Repair Sidewalk	1991	1,030						57
58	Roof Repair	1991	27,243						58
59	Water Heater	1992	3,300						59
60	Water Heater	1992	3,150						60
61	Fire Alarm/Smoke Detector	1992	504						61
62	Fire Alarm/Smoke Detector	1993	2,921						62
63	Cubicle Curtains	1993	22,395						63
64	Driveway	1993	2,010						64
65	Carpet	1993	1,710						65
66	Compressor	1994	350						66
67	Nurses Stations	1994	1,042						67
68	Water Heater	1994	5,645						68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,065,715	$ 62,195		$ 62,195	$ 0	$ 1,438,159	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,065,715	$ 62,195		$ 62,195	$	$ 1,438,159	1
2	Landscape	1982	318						2
3	Building	1982	8,500						3
4	Landscape	1984	449						4
5	Landscape	1984	1,486						5
6	Storage	1989	29,469						6
7	Energy Management System	1995	8,325						7
8	Handrails	1996	750						8
9	Tile Flooring	1996	374						9
10	Carpeting	1997	2,240						10
11	Dormer Repair	1997	8,046						11
12	Emergency Arcing	1997	2,659						12
13	Exterior Masonry Waterproofing	1997	3,991						13
14	Engineering Costs - Underground Storage Tank Removal	1997	3,000						14
15	Tile Flooring	1998	9,002						15
16	Soffit & Fascia	1998	9,400						16
17	Heat Pump Compressors	1998	2,637						17
18	Overhead Heat Pump	1998	672						18
19	2 L-Shaped Counter Tops	1999	1,300						19
20	Fascia & Ceiling Panels	1999	595						20
21	Counter Top	1999	480						21
22	2 Counter Tops	1999	640						22
23	Vinyl Blinds	1999	757						23
24	Painting - Resident Rooms	1999	25,856						24
25	Painting - N & S Lounges	1999	7,194						25
26	Carpeting - Nurses Station	2000	579						26
27	Roof - Generator Room	2000	500						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,194,934	$ 62,195		$ 62,195	$	$ 1,438,159	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,194,934	$ 62,195		$ 62,195	$	$ 1,438,159	1
2	Building	1993	16,906						2
3	Building	1994	489,387						3
4	Landscape	1994	1,600						4
5	Landscape	1994	350						5
6	Building	1995	101,007						6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,804,184	$ 62,195		$ 62,195	$	$ 1,438,159	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,804,184	$ 62,195		$ 62,195	$	$ 1,438,159	1
2	Landscape	1995	2,719						2
3	Building	1996	479						3
4	Landscape	1996	1,505						4
5	Building	1997	1,251						5
6	Landscape	1998	2,966						6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,813,104	$ 62,195		$ 62,195	$	$ 1,438,159	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,813,104	$ 62,195		$ 62,195	$	$ 1,438,159	1
2	Storm Sewer	2001	18,898						2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,832,002	$ 62,195		$ 62,195	$	$ 1,438,159	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 437,284	$ 43,474	$ 43,474	$		$ 194,512	71
72	Current Year Purchases	14,791	1,148	1,148			1,148	72
73	Fully Depreciated Assets	266,416					266,416	73
74								74
75	TOTALS	$ 718,491	$ 44,622	$ 44,622	$		$ 462,076	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	1992 Chevy Truck	1992	$ 19,382	$	$	$	4	$ 19,382	76
77	Staff Transportation	1997 Dodge Van	1997	16,993	3,399	3,399		5	15,295	77
78										78
79										79
80	TOTALS			$ 36,375	$ 3,399	$ 3,399	$		$ 34,677	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,635,868	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 110,216	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 110,216	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,934,912	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Farm Land (5 acres) 1993	$ 12,427	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 12,427	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable - McDonough County/Macomb Public Building Commission - See page 11 note

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,230,646	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	400,541		3
4	Supply Inventory (priced at)	42,846		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,556		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	3,524		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,680,113	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	61,427		13
14	Buildings, at Historical Cost	3,046,125		14
15	Leasehold Improvements, at Historical Cost	785,877		15
16	Equipment, at Historical Cost	754,866		16
17	Accumulated Depreciation (book methods)	(1,934,912)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,713,383	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,393,496	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 73,810	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,676		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Vacation	103,591		36
37	Accrued Provider Tax, Due to County	22,511		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 240,588	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 240,588	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,803,519	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,044,107	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,202,312	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,202,312	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(428,010)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment	29,217	14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (398,793)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,803,519	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,188,450	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,188,450	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,830	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,830	23
	D. Non-Operating Revenue		
24	Contributions	5,884	24
25	Interest and Other Investment Income***	65,457	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 71,341	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Other-See attached schedule**	56,922	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 56,922	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,319,543	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	956,459	31
32	Health Care	1,922,527	32
33	General Administration	667,330	33
	B. Capital Expense		
34	Ownership	147,562	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	53,675	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,747,553	40
41	**Income before Income Taxes (line 30 minus line 40)****	(428,010)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (428,010)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,864	2,200	$ 55,194	$ 25.09	1
2	Assistant Director of Nursing	1,678	1,990	40,093	20.15	2
3	Registered Nurses	18,561	20,957	354,683	16.92	3
4	Licensed Practical Nurses	20,958	23,957	306,587	12.80	4
5	Nurse Aides & Orderlies	78,100	88,682	868,481	9.79	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,832	2,104	27,581	13.11	9
10	Activity Assistants	6,842	7,623	62,605	8.21	10
11	Social Service Workers	3,435	4,345	57,310	13.19	11
12	Dietician					12
13	Food Service Supervisor	3,499	3,918	49,046	12.52	13
14	Head Cook	6,582	7,067	59,358	8.40	14
15	Cook Helpers/Assistants	8,521	9,787	82,066	8.39	15
16	Dishwashers	9,959	11,073	75,017	6.77	16
17	Maintenance Workers	5,967	6,865	82,133	11.96	17
18	Housekeepers	15,379	17,543	141,658	8.07	18
19	Laundry	5,828	6,736	62,005	9.21	19
20	Administrator	1,856	2,160	66,901	30.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,888	2,216	43,224	19.51	23
24	Clerical	6,118	7,171	66,221	9.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,777	2,057	19,309	9.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	200,644	228,451	$ 2,519,472 *	$ 11.03	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	97	$ 4,360	1,3	35
36	Medical Director	12	360	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	1,200	10,3	39
40	Physical Therapy Consultant	96	8,400	10a,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	29	1,461	11,3	44
45	Social Service Consultant	29	1,461	12,3	45
46	Other(specify)				46
47	Computer Consultant	66	6,539	19,3	47
48					48
49	TOTAL (lines 35 - 48)	353	$ 23,781		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Charles Kneedy	Administrator	None	66,901
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 66,901

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Clifton Gunderson LLP	Auditing	$ 5,800
Computer Masters	EDP Consulting	6,539
Claudon, Kost, Barnhart, and	Legal Fees	175
Beal, Ltd.		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 12,514

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,577
Unemployment Compensation Insurance	6,904
FICA Taxes	181,701
Employee Health Insurance	395,544
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	124,154
Employee Physicals	3,160
TOTAL (agree to Schedule V, line 22, col.8)	$ 771,040

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,645
Health Care Worker Background Check	500
(Indicate # of checks performed 32)	
County Nursing Home Association	980
Life Services Network	4,287
Illinois Nursing Home Administrator's	75
MES/HPS	175
Misc. Dues and Subscriptions	216
Less: Public Relations Expense	(2,816)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,062

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,615
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,615

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Elms # 0021568 Report Period Beginning: 12/1/00 Ending: 11/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Schedule F, Page 21**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,273** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **53,675**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,830**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Clifton Gunderson LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **See attachments, Page 25**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.